FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38900
STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 112

1. PLACE OF DEATH
a. COUNTY Sullivan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY Sullivan
c. CITY OR TOWN Milan 1050 0 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Paul Middle Last Glidewell
4. DATE OF DEATH Month 10 Day 25 Year 1957
5. SEX M 0
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-2-1867
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months 1 Days 23 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Milan - Mo 0
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME James Glidewell
14. MOTHER'S MAIDEN NAME Sarah Black
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 496-42-4868
17. INFORMANT Mrs Paul Glidewell — Address Milan, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intensity 9 — INTERVAL BETWEEN ONSET AND DEATH 72 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senile changes — —
DUE TO (c) — 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 481X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 10-23-57 to 10-25-57 and last saw ~~her~~ him alive on 10-25-57
Death occurred at 4 30 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. W. Simpson, D.C. 2
22b. ADDRESS Milan
22c. DATE SIGNED 10-25-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-27-57
23c. NAME OF CEMETERY OR CREMATORY Oakwood Cem.
23d. LOCATION (City, town, or county) Milan (State) Mo

24. FUNERAL DIRECTOR Schoenes Dwight Schoene — ADDRESS Milan Mo
25. DATE RECD. BY LOCAL REG. 10-29-57
26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed....Dwight Schoene.....

Licensed Embalmer No..266

P. O. Address Milan - M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.